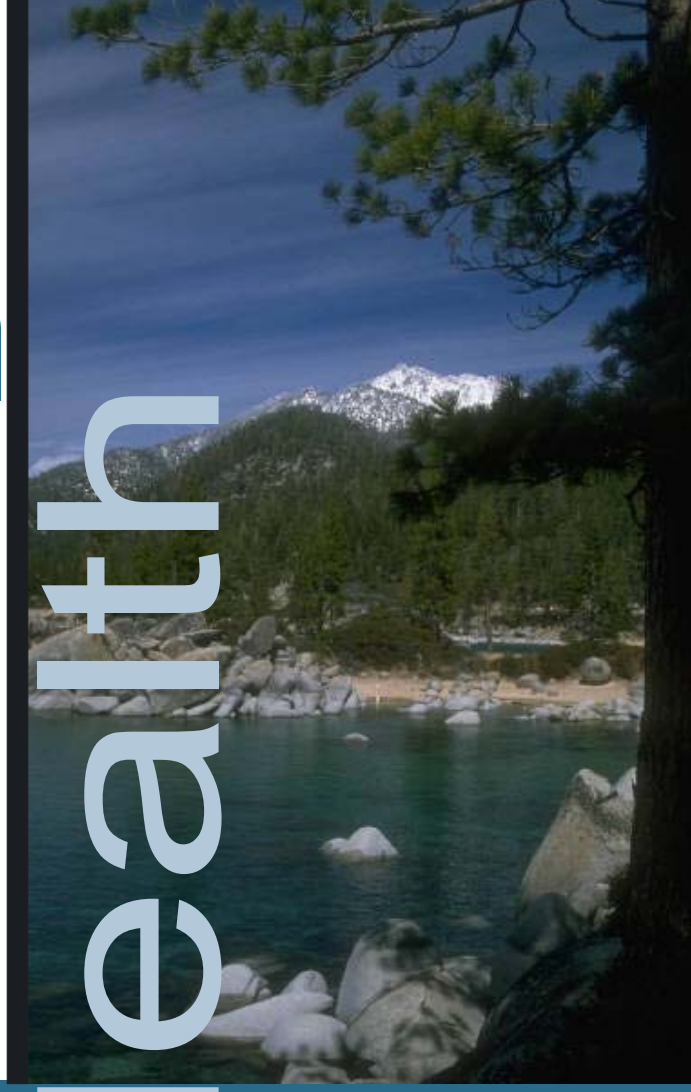
Nevada Health

Informational Newsletter Published by the
Nevada State Health Division
Office of Public Information



New Health Division Administrator Selected

Alex Haartz has been selected as Administrator for the Nevada State Health Division. Mike Willden, Director, Dept. of Human Resources, announced the appointment of Haartz in mid-July 2004, after an extensive nationwide search.

Haartz began service with the state of Nevada in 1994, in the Bureau of Family Health Services, Nevada State Health Division. He holds a Master of Public Health degree from Tulane University, with emphasis in

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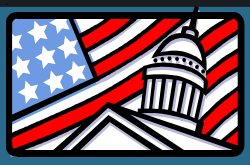


Mission Statement

Promote and protect the well-being of Nevadans and visitors to our state by preventing disease, injury, and disability.

Summer 2004

Health Division officials ready to "Meet the Press"

By Annie Uccelli, Public Information Officer, Public Health Preparedness Program

"You should never be surprised by anything you say." When it comes to dealing with the media, truer words were never spoken. Although it's a task some may dread, a group of Health Division employees recently learned that a little confidence and a lot of preparation can make most media interviews a positive experience.

The Nevada State Health Division's Public Health Preparedness Program brought national media expert **Kelly Burke** (photo left) to Carson City for a full day of workshop media training, followed by two hours of intensive on-camera training. Participants included Health Division employees from the Bureau of Community Health, Bureau of Health Planning and Statistics, Bureau of Health Protection Services, Bureau of Alcohol and Drug Abuse, Bureau of Family Health Services, Administration and Public Health Preparedness, along with staff from the Nevada Department of Agriculture, Clark County Health District and Washoe County District Health Department.

While everyone was a little camera-shy at first, many of the participants were surprised to learn that they had more skills in dealing with the media than they thought. Several participants excelled at showing empathy and concern during a disaster, and others were skilled at handling difficult questions from reporters at a news conference.

Burke's video examples of high-profile newsmakers illustrated interview traps, and highlighted the importance of determining an agency's message and sticking to it throughout an interview. The group watched as Senator Bob Dole took Katie Couric's bait during a heated "Today Show" interview, and U.S Postmaster General John Potter was viewed as uncaring and defensive in a series of media interviews during the Washington, D.C. anthrax mail scare.

Other common pitfalls that agency spokespeople face when dealing with the media include being led astray from the message by a reporter's line of questioning and forgetting who is the real audience (hint: not the reporter conducting the interview).

Burke knows what he's talking about. This media veteran spent 20 years on the other side of the camera as a television reporter in Detroit, Cleveland and Washington, D.C. Since leaving television news, Burke has taught courses at Chicago's Northwestern University, and also founded *KELCOM*, a media consulting firm whose clients include the Red Cross, National Institutes of Health and the Centers for Disease Control and Prevention.

Burke's best advice? He urged the group to remember, when it comes to the media, "You're always on." He cautioned, "If you don't want to read it, see it or hear it, don't say it !"

Safety Tip:
Planning an Emergency Escape Route

Every year, nearly 4,000 Americans die in home fires and approximately 25,000 are injured. Children and the elderly are especially at risk in home fires because they are less able to escape when fire strikes. You can improve the chance that your family will survive a home fire by making sure that they can escape quickly. These tips, courtesy of the U. S. Fire Administration, are provided to help create an escape plan.

Smoke alarms are life-savers. The primary fire safety strategy for any home is to warn the occupants early. The best way to get the early warning of danger is by installing sufficient smoke alarms. Homes should have a smoke alarm near the bedrooms, but not so close to the kitchen that you have problems with alarms from cooking. It's a good idea to have a smoke alarm in each bedroom, especially if you sleep with the door closed.

Plan your escape: The other part of the fire safety plan is for everyone to get out quickly. If you awake in the middle of the night to a fire, your thinking and reaction time may be confused. Therefore, it is important that you practice your escape plan ahead of time. That way, your whole family will know what to do. Manufactured homes have more ways to escape than most other homes. There are always two doors, and every bedroom has an emergency escape window. Make sure everyone knows how to open the windows in your home so no time is wasted when fire strikes. These windows are labeled with operating instructions. Everyone in the family, as well as frequent visitors and babysitters, should practice the escape plan, including opening the escape windows.

Can you beat the clock? Most people do not realize how quickly fires can grow. A home fire can become deadly in as few as three minutes. Can your family get out that quickly? Consider that it may take one minute for the smoke alarm to sound and for you to recognize the danger. If you have young children or are elderly, you may need another minute to get ready. This leaves only one minute for everyone to get to an exit, open it and get out. By practicing your escape, you can make every second count.

Steps to a safe escape:

- Have at least two working smoke alarms, and test them monthly.
- Plan two ways out of every room.
- Practice your escape plans twice a year.
- Practice crawling low under the smoke.
- Have a pre-arranged meeting place outside your home.
- Call the fire department from a neighbor's home.
- Once you're outside, stay out.

For more information or for a schedule of training courses offered at no charge by SCATS, call toll free 1.877.4SAFENV [1-(877)–472-3368].
Or visit: www.4safenv.state.nv.us.

WebIZ Is Now Available Statewide!

Nevada's WebIZ registry is now available to private providers, schools, health plans and other agencies, statewide. This past July, WebIZ was moved from the Health Division's network to Internet access for northern users after software testing and enhancements were completed. The inclusion of the Clark County's WebIZ database to the state's WebIZ registry this month will allow Internet access of WebIZ for southern users and complete statewide access. The web enabling of the state's registry will provide easy access for providers with minimal hardware and software requirements, thus we hope that private provider participation will increase.

Why use WebIZ?

- Maintain accurate immunization histories of children
- Provide health care providers with rapid access to immunization data
- Determine when immunizations are due (reminder/recall)
- Notify parents when children are due for immunizations
- Facilitate vaccine inventory control and accountability
- Assess current levels of immunization coverage

What are the benefits?

For Providers

- Keeps accurate immunization histories on pediatric patients
- Maximizes staff time by reducing needless searches for lost records
- Reduces missed opportunities to vaccinate
- Reduces duplication of immunizations and paperwork
- Reduces missed appointments
- Assists in the collection of HEDIS documentation
- Keeps track of vaccine history and vaccine usage
- Provides "real time" immunization assessment levels of patients

For Parents

- Readily available records needed for entrance to child care and schools
- Reminders to assist in keeping children on schedule for their immunizations
- Eliminates "over-immunizing" and reduces costs

For Communities:

- Helps control vaccine preventable diseases
- Increases immunization rates
- Helps identify high-risk and under-immunized populations
- Will link with other databases to improve the health of children
- Provides information on community and state coverage rates

For more information on WebIZ or for enrollment criteria, call the Nevada State Immunization Program at: (775) 684-5900. In Washoe County, call the Health District's Immunization Program at : (775) 328-2477.

Public Health Preparedness funds award-winning program

By Annie Uccelli, PIO, Public Health Preparedness

A Public Health Preparedness Program partner has taken center stage in the national spotlight. Southern Nevada Area Health Education Center (AHEC) is the proud recipient of honors from their national organization, in recognition of a series of bioterorrism training programs they developed in response to September 11. Southern Nevada AHEC Public Health Preparedness Education Department (PHPED) received an "Award of Excellence for Continuing Education" at the 2004 National AHEC Organization (NAO) Workshop held in Baltimore, Maryland in August. The NAO currently operates in 43 states across the country.

Southern Nevada AHEC Executive Director Rose Yuhos, R.N., said, "This award belongs to the staff. I'm so proud of their hard work!" Yuhos also noted that Southern Nevada AHEC strong partnership with the Nevada State Health Division's Public Health Preparedness Program was an important factor in the group's success.

Southern Nevada AHEC is a non-profit organization dedicated to improving Nevada's health status. Their mission is to improve Nevada's health status through education, including continuing education for health care professionals.

The Southern Nevada AHEC department was honored for their quick assessment of training needs in response to September 11, 2001. PHPED created, promoted and implemented six new programs to enable trainees to recognize and respond to acts of biological terrorism and other public health threats and emergencies. Two of those programs are training for the Strategic National Stockpile Rollout plan and Weapons of Mass Destruction training, which meets the requirements of Assembly Bill 250. Since 2002, the department's training has reached more than 5,400 health care professionals and first-responders in Nevada and the surrounding regions.

NAO Awards Committee Chair Thomas J. Bacon described Southern Nevada AHEC achievements as a national model. "Their project stands as an exemplar for other AHEC programs. It is indeed projects of this level of excellence for which national recognition was intended."

Southern Nevada AHEC serves Nevada's four southern counties: Clark, Esmeralda, Lincoln and Nye. This diverse service area includes the most densely populated part of the state (Clark County contains 70 percent of the state's population), as well some of the state's most sparsely populated rural and frontier areas. Additionally, Southern Nevada AHEC is the largest of the three programs in the Nevada AHEC system.

These award-winning training programs were developed and conducted with funding from the Nevada State Health Division through a grant from the Centers for Disease Control and Prevention.

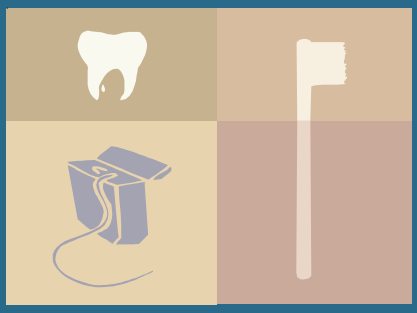
Fight the Bite: West Nile Virus Update

Dr. Vicky Fogelman
Public Health Veterinarian

West Nile virus has come to Nevada. The West Nile virus (WNV) is a mosquito transmitted virus first recognized in the U.S. in New York City in 1999. It had previously been known to occur primarily in Africa, Southwest Asia and the Middle East. The virus normally cycles between mosquitoes and birds, but man, horses and certain other animal species can become incidental hosts. Since 1999, the virus has quickly spread across the United States and now has been identified in humans and/or animals in the Continental United States. WNV was first detected in Nevada early this summer in a dead crow found in Carson City. The Nevada Department of Agriculture has since identified the virus in mosquitoes, birds and horses throughout the state. Nevada has also reported 40 cases of WNV related human illness so far this year. California has reported over 600 cases, and Arizona has reported over 350 cases of WNV infection this year. Once the virus has established itself in an area, it continues to cycle in the mosquito and bird populations. This means that we can expect to see additional cases of West Nile virus infection in both humans and other animals in subsequent years. Most humans who are infected with WNV do not become ill. However, about 1 in 5 infected individuals develops a flu-like syndrome known as West Nile fever, and about 1 in 150 develops serious neurological disease, including meningitis, encephalitis or a polio-like paralysis. West Nile fever symptoms may include fever, headache, body aches, fatigue and muscle weakness. The symptoms may last for as few as three days or as long as several weeks. People over 50 years of age are at greatest risk of developing serious illness from this virus.

Individuals can take specific actions to protect themselves from becoming infected with WNV by wearing mosquito repellent containing DEET, avoiding unprotected outside activities during peak mosquito biting periods (dawn, dusk and just after dark), removing standing water from around homes and gardens, providing mosquito-eating fish for ornamental ponds, and repairing or replacing damaged screens. There is no vaccine available for humans yet, although there is a very effective vaccine available for horses. It is very important to take precautions against mosquitoes when working or recreating outside in West Nile infected areas. Many cases of human illness have a history of exposure to mosquitoes during camping trips, gardening, or working in outdoor occupations. For more information on the virus, its potential health effects, and how you can protect yourself, see the Nevada State Health Division web page at: health2k.state.nv.us

The Nevada State Health Division is part of a West Nile Working Group which is working hard to coordinate and promote activities to help prevent transmission of West Nile virus (WNV) to humans. This group includes representatives from the Nevada Department of Agriculture, mosquito control agencies throughout the state, Washoe and Clark County Health Districts, and the Indian Health Service. Areas of emphasis include public education, targeted vector control and development of mutual support agreements between counties and mosquito abatement districts. Establishment of this group has greatly enhanced communication and cooperation between all agencies involved with WNV prevention and control.



The ***Oral Health Program*** is pleased to announce the release of a number of new reports: the 2004 State Oral Health Plan, the Burden of Oral Disease 2004 and the 2004 Healthy Smile–Happy Child, Head Start Oral Health Survey. The 2004 State Oral Health Plan was developed with input from over 70 stakeholders. It is a guide for not only the Oral Health Program, but also for stakeholders throughout Nevada. It includes goals and objectives in four categorical areas: Infrastructure Building, Population-Based Services, Direct Health Services and Enabling Services.

The Burden of Oral Disease 2004 provides a concise summary of oral health data for preschoolers, third graders, adolescents, adults and seniors. It reports on data collected using the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey, the Behavior Risk Factor Surveillance Survey (BRFSS), the Cancer Registry and data collected by the University of Nevada Las Vegas, School of Dental Medicine, Crackdown on Cancer program. The 2004 Healthy Smile–Happy Child, Head Start Oral Health Survey analyzes data collected when 1,677 children from every Nevada Head Start program participated in a visual screening. Data collected included decay experience, untreated decay, and treatment urgency. Data is reported by region, race/ethnicity, and insurance status. The reports are all available at: www.health2k.state.nv.us/oral.

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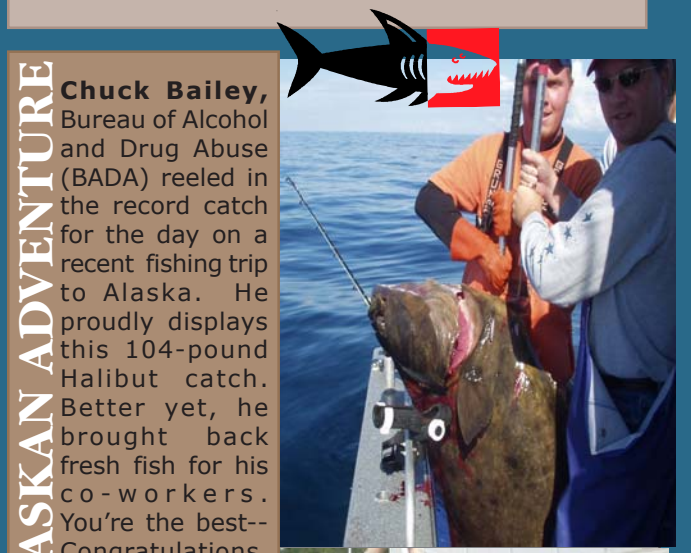
epidemiology and education. He previously served as the Administrative Services Officer, and Deputy Administrator for the Nevada State Health Division, immediately prior to his appointment. Haartz practices a philosophy of surrounding himself with the best and the brightest. "I'm a firm believer that successful leadership is dependent upon solid teamwork--staff is the most valuable asset in this organization," said Haartz in a recent interview. He forsees a growing challenge for public health partners in Nevada as a direct result of Nevada's rapidly expanding population growth. "We need to adapt to meet the public health needs of Nevadans in our large counties, as well as our rural and frontier counties. Our goal is to think smarter to ensure our scarce public funds are allocated and spent wisely and appropriately."

ALASKAN ADVENTURE

Chuck Bailey, Bureau of Alcohol and Drug Abuse (BADA) reeled in the record catch for the day on a recent fishing trip to Alaska. He proudly displays this 104-pound Halibut catch. Better yet, he brought back fresh fish for his co-workers. You're the best--Congratulations, Chuck!



Nevada HMO Industry Profile

By Lynn O'Mara, Bureau of Health Planning and Statistics

The Bureau of Health Planning and Statistics has been issuing the *Nevada HMO Industry Profile* since 1996. Published quarterly, the report contains valuable information regarding Nevada's licensed health maintenance organizations (HMOs) and certain preferred provider organizations (PPOs). Each quarterly report presents company-specific organizational information, as well as quarterly enrollment data arranged by county, enrollment data area-categorized by enrollee population and product (i.e. Commercial Plan, Medicare, Medicaid, Nevada Check Up) and market penetration information. The profile provides a snapshot of health care utilization, availability and accessibility throughout Nevada.

According to **Emil DeJan**, Bureau Chief, Health Planning and Statistics, "The *Nevada HMO Industry Profile* has been the single-most useful report we publish. At one time, it had a mailing list of over 500. Today, with its availability on the Nevada State Health Division's website, that list has been reduced to about 150." DeJan continued, "That does not mean the profile's popularity has decreased. We continue to receive requests for copies of the report, as well as requests for the specific kinds of data it provides. Many of the inquiries come from out-of-state agencies, and the profile has been used as a model by other states interested in publishing similar kinds of information."

The report is used by the health care industry, hospitals, the media, ambulatory surgery centers, physicians, the insurance industry, consumers, and others, inside and outside Nevada, interested in managed care services within the state. It is also an excellent reference for the state Board of Health, as well as the state Legislature, Division of Insurance, and many agencies within the Department of Human Resources. The profile data are provided on a voluntary basis by the managed care providers, and aids the Nevada State Health Division in its routine monitoring of related HMO activities.

It is important to note that HMOs and PPOs are two distinctively different approaches to health care coverage. An HMO is an organization or health plan that offers prepaid, comprehensive health coverage, for both hospital and physician services, to voluntarily enrolled individuals and families for specific periods of time. In comparison, a PPO is an organization that offers a variety of benefit plans as fee-for-service products and gives economic incentives to the individual purchaser of a health care contract (also known as the beneficiary) to utilize certain physicians and medical facilities at reduced fees. Because of the differing approaches, service delivery of the two types of health care providers may differ. Additionally, an HMO and a PPO may both be part of the total health care product line from the same insurance company. While the HMO information presented in the *Nevada HMO Industry Profile* represents the currently-licensed HMOs in the state, the PPO information is not an exhaustive listing of all PPOs that are operating within Nevada. The voluntary PPO data presented in the profile are solely to provide an indication of other managed care activities with which the HMO may be involved.

Health Passport Smart Card Program

The Nevada State Health Division's, Women, Infants and Children (WIC) program has received approval from the United States Department of Agriculture to continue the rollout of the WIC Health Passport Smart Card program to 7 clinics and 62 stores in Las Vegas.

The Health Passport Smart Card, an Electronic Benefits Transfer (EBT) program, began as a pilot project initiative of the Western Governor's Association. It utilizes a computer chip on an ATM-like debit card to deliver food to WIC participants. The program has been running successfully in Washoe County since June 2000 and has received an unprecedented level of client and retail vendor support. Clients like the card because they can use it to purchase nutritionally approved foods from any number of participating grocery stores. It allows them to purchase food where they like and when they like, rather than from only one store and all at once under the current voucher system. Vendors like the program because their stores are reimbursed for purchases electronically on a daily basis. The vendors have expressed their approval not only vocally during quarterly WIC Vendor Council meetings but also through their unanimous agreement to become EBT partners by purchasing additional lanes of EBT equipment at their own expense.

Currently, 7,000 clients and 32 stores in Washoe County participate in the EBT program. The program has received accolades from across the country, most recently from United States Undersecretary of Agriculture, Eric Bost, and United States Surgeon General **Richard Carmona** (photo below). Both men were in Reno recently to receive a tour of the clinic and a demonstration of what many people have referred to as the most modern benefits delivery program in the United States. Expansion into the clinics and store in Las Vegas is expected to begin in January 2005.

WIC
Women, Infants, and Children

HIV Counseling with Rapid Tests

By Lyell S. Collins, HIV Prevention Program Coordinator

Why Provide Rapid HIV Testing?

Approximately 2.1 million HIV tests are conducted annually in publicly funded counseling, testing, and referral (CTR) programs. However, many persons do not return for the results of standard tests: 30 percent of persons who tested HIV-positive during 2000 and 39 percent of persons who tested HIV-negative did not return. Almost all clients receive their rapid HIV test results because results can be provided immediately during the testing visit.

How Do Rapid HIV Tests Compare with Standard HIV Screening Tests, Enzyme Immunoassays (EIAs)?

Clinical studies have demonstrated that the sensitivity and the specificity of rapid HIV tests are comparable to those of EIAs often used for screening. The negative predictive value[4] of a screening test is high at the HIV prevalence observed in most U.S. testing settings (CDC, 1998). Therefore, a client with a negative rapid HIV test result can be told he or she is not infected. However, because HIV antibodies take time to develop, retesting should be recommended to persons with a recent possible exposure (sexual contact or needle sharing within 3 months). As with any screening test, the positive predictive value of a reactive rapid HIV test may be low in populations with low prevalence. Because some reactive test results may be false-positive, every reactive rapid test must be confirmed by a supplemental test (either Western Blot or Immunofluorescence Assay [IFA]). (CDC, 1989).

HIV Counseling with Rapid HIV Tests:

HIV counseling encompasses two components: provision of information and prevention counseling (CDC, 2001a). All clients must receive information about the rapid test and give informed consent for testing. Clients who can benefit should also receive prevention counseling.

Information: Information can be provided either in a face-to-face meeting with a counselor or in a pamphlet, brochure, or video. Clients tested with a rapid HIV test should be given the same types of information recommended for those tested with a standard EIA. Such as:

- Information about the HIV test, its benefits and consequences.
- Ways HIV is transmitted and how it can be prevented.
- The meaning of the test results in explicit, understandable language.
- Where to obtain further information and, if applicable, HIV prevention counseling.
- Where to obtain other services including, if applicable, treatment.

In addition, clients tested with rapid HIV tests should be

- Advised that their rapid test results will be available during the same visit.
- Informed that confirmatory testing is needed if the rapid test result is reactive.

Communicating the Meaning of the Rapid HIV Test Results: ***Negative Rapid HIV Test Results.*** During the initial visit, the provider can definitively tell clients whose rapid HIV test result is negative that they are not infected, unless they have had a recent (within 3 months) known or possible exposure to HIV. Retesting should be recommended for these clients because sufficient time needs to elapse before antibodies develop that can be detected by the test.

Reactive (Preliminary Positive) Rapid HIV Test Results. Further testing is always required to confirm a reactive (preliminary positive) screening

Nevada Revised Statutes Chapter 652 Medical Laboratories and federal law (CLIA) governing laboratory testing, require appropriate certification prior to the performance of any testing. The Rapid HIV test kits are not available over-the-counter for home use, and are to be distributed to laboratories only. They are not intended to be used by an individual in their home setting, such as a finger-stick glucose test. You may contact the Bureau of Licensure and Certification at: (775) 687-4475 for additional information to become certified to perform HIV rapid testing.

test result. Providing reactive (preliminary positive) results to clients without the benefit of a same-day confirmatory test can be a challenge. For all clients with a reactive rapid HIV test result, however, it is essential to:

- Explain the meaning of the reactive test result in simple terms, avoiding technical jargon.
- Emphasize the importance of confirmatory testing and schedule a return visit for the confirmatory test results.
- Underscore the importance of taking precautions to avoid the possibility of transmitting infection to others while awaiting results of confirmatory testing.

A simple message to convey this information could be "Your preliminary test result is positive, but we won't know for sure if you are infected with HIV until we get the results from your confirmatory test. In the meantime, you should take precautions to avoid transmitting the virus."

HIV Prevention Counseling: Fundamentals of HIV prevention counseling with rapid HIV tests include:

- Keep the session focused on HIV risk reduction.
- Include an in-depth, personalized risk assessment.
- Acknowledge and provide support for positive steps already made.
- Clarify critical rather than general misconceptions about HIV risk.
- Negotiate a concrete, achievable behavior-change step that will reduce HIV risk.
- Seek flexibility in the counseling technique and process, avoiding a "one-size-fits-all" approach.

With standard testing, there are always two test-associated opportunities for prevention counseling for clients who return for their results. With rapid testing, there may be either one or two.

- o Clients with preliminary positive rapid HIV test results also have two test-associated opportunities — one on the day of testing and one when they return for their confirmatory results.
- o Clients with HIV-negative rapid HIV test results usually have only one test-associated opportunity. They will not have an opportunity to try out their risk-reduction plan or to discuss with the counselor their attempts at carrying it out before they receive their HIV result. However, at the visit when the rapid testing is done, if the counselor thinks that the client's risks warrant additional prevention counseling after negotiating and discussing a risk-reduction step, he or she can schedule a second appointment with the client for this purpose.

HIV prevention counseling with a rapid HIV test completed in a single visit has been successfully implemented in several settings in the United States over the past several years with the SUDS (Single Use Diagnostic System for HIV-1) rapid test. Experience has shown that this form of prevention counseling is feasible and is well accepted by most clients and counselors. An example of a counseling protocol for providing prevention counseling during one visit for clients receiving rapid test results and materials for counselors can be found at the RESPECT-2 web site. The OraQuick test may introduce some differences, because, unlike the SUDS test (which is sent to the lab) it may be possible for the counselor both to perform the test and to provide the counseling,

Future of Rapid HIV Testing: Several other rapid HIV tests already being used outside the United States will likely be considered for FDA approval. Many of these tests require a single step, can be performed on whole blood, serum, plasma, oral fluid, or finger-stick blood samples, and provide results within minutes. These tests also have a high sensitivity and specificity (Branson, 2000). When these tests become available, it may be possible to implement strategies such as one recommended by the World Health Organization (WHO, 1997) whereby specific combinations of different rapid tests might be used to confirm reactive rapid HIV test results immediately.

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The Bureau of Health Planning and Statistics has released the ***Report on Cancer in Nevada.*** Under the direction of Dr. Wei Yang, the Center for Health Data and Research announces the completion of 'Report on Cancer in Nevada,' available for viewing online at: **http://health2k.state.nv.us/cancer/**

This report provides a comprehensive overview of the risks and burden of cancer in Nevada from 1997 to 2001. The report provides a variety of information on cancer from four different data sources and has been organized to focus on specific aspects of cancer, (e.g. screening, diagnosis, inpatient treatment, mortality, and survival rate) with each section adding to the overall picture of cancer in Nevada.

NEVADA DIABETES PREVALENCE UNCHANGED FROM 2002 TO 2003

By Bill Kirby
Bureau of Community Health

Diabetes prevalence among Nevada adults showed a negligible change from 2002 to 2003; increasing from 6.2 percent to 6.3 percent. Nationwide, diabetes prevalence increased from 6.7 percent to 7.1 percent. In both years, diabetes prevalence in Nevada was lower than prevalence nationwide. However, there are some perceptible changes in gender, race, age group and region.

Gender

- Increased in males from 7.1% to 7.4%.
- Decreased in females from 5.4% to 5.1%.

Racial/Ethnic Group

- Increased in Caucasians from 5.9% to 6.6%.
- Increased in African-Americans from 9.4% to 10.1%.

Age Group

- Increased in 45-54 year olds from 6.9% to 7.7%.
- Increased in the 65 and older population from 14.3% to 15.4%.

Region

- Increased in Clark County from 6.2% to 6.6%.
- Increased in Washoe County from 5.1% to 5.6%.

It is important to remember that trends must be followed over several years. This data is a snapshot for 2002 and 2003.

EARLY INTERVENTION SERVICES--ACCOMPLISHMENTS AND CELEBRATION OF FIRST YEAR AS HEALTH DIVISION BUREAU

July 1, 2004 marked the first anniversary of Nevada's Early Intervention Services' consolidation into one program within the Nevada State Health Division. Prior to July 1, 2003, five separate early intervention programs in the Divisions of Health and Child and Family Services operated within the Nevada Department of Human Resources (DHR). In addition, the Part C, IDEA Office was located within the Community Connections Unit of the Department of Human Resources (DHR), Director's Office.

Each early intervention program had a different mission, philosophy, types of programming and different methods used to collect child data. It was also reported that it was confusing to southern Nevada parents which early intervention program to contact for services since there were two programs providing similar services in that area.

Children were waiting for services beyond the 45 day timeline in all regions. Population growth within southern Nevada was seriously impacting services, with programs in the south receiving as many as three times the number of new referrals compared to the number of children exiting the program at age three.

New Beginnings-July 1, 2003

The Bureau of Early Intervention was created, under the leadership of **Janelle Mulvenon** and the BEIS management team, to consolidate all early intervention programs and the Part C, IDEA Office in order to create a unified approach in the provision of early intervention services. This continuity would create a better referral system and increased community awareness of services, implementation of "best practices" in the field of early intervention services and elimination of the waiting list for services. Under Part C, IDEA federal regulations, a child must not wait longer than 45 days from the date of referral to determine eligibility and develop an Individualized Family Service Plan. Recognizing that no substantive increases had occurred for early intervention services during the past three legislative sessions, Governor Guinn recommended more money for early intervention services in the Executive Budget for Fiscal Years 2004 and 2005. The 2003 Nevada Legislature approved additional general funds in the amount of $3,592,522 over the biennium and increased Medicaid and federal grant authority of $1,930,835 for these two years. July 1st arrived with the Bureau of Early Intervention Services existing in name only. This new bureau now consists of two regions (northern and southern) including adjacent rural counties. All early intervention programs now have a common name, Nevada Early Intervention Services. No specific early intervention program policy or procedural manuals existed at the onset of this new bureau and existing staff that transferred from the Director's Office and Division of Child and Family Services were also learning the culture of the Health Division. Simultaneously, every employee, whether in the former Part C, IDEA Office, Division of Health or Division of Child and Family Services,

realized that everyone would be affected in establishing this new bureau.

Challenges

The Bureau of Early Intervention Services established these goals for FY 04:

- All children needing services will receive appropriate early intervention services within 45 calendar days.
- All children will start school ready to learn and ready to transition to the school system/community resources at the age of three
- Utilizing best practices and family-centered services, create a seamless early intervention system.
- Achieve overall compliance with the Part C, IDEA requirements.

Accomplishments

The Bureau of Early Intervention Services offers four programs within the northern and southern regions:

1. Part C, IDEA Early Intervention Services
2. Specialty Clinics – i.e. Metabolic, Genetic, Craniofacial (Supported by Maternal and Child Health Funds)
3. Hearing Screenings
4. Screening and Monitoring Program

The Part C Office, located within the Bureau of Early Intervention Services, provides monitoring/compliance, training and technical assistance to the early intervention programs.

The key to the accomplishments listed below has been, and continues to be, the commitment of the early intervention staff. Every member of the bureau has contributed to these successes.

- The bureau held six strategic planning meetings to outline desired components and established a mission and guiding principles.
- Increased staff with the additional funds granted by the Nevada Legislature.
- A new staff two-day training curriculum was developed by the Part C, IDEA Office, and these trainings have been held regularly at the regional sites.
- The enhanced computerized child management data system was released in December 2003. Verification and "clean-up" data has continued every month with each month resulting in providing more accurate child information.
- Regional parent advisory committees have been established and meet quarterly to advise the regional programs.
- Multi-disciplinary teams have been established and are developing their guidelines at each regional site.
- Statewide, a family survey was sent to 900 families in March 2004 with a 20 percent return rate. Survey results indicated that 90.6 percent of families indicated that their child benefited from early intervention services.

- 182 computers, 5 file servers, phone system upgrades, firewalls, routers, and printers were purchased and installed in the regional program sites.

- One centralized referral number and common intake procedures were established in the southern region.

- Part C, IDEA conducted focused-monitoring visits at all program sites. Regional corrective action plans and improvement plans are being prepared to address deficiencies.

- Seven new supervisory positions were added statewide to provide guidance to new staff. Prior to this addition, supervisor/staff ratios were as high as 35 to 1.

- The Reno site has worked with the Public Works Board and Worth Group Architect in preparing for the release of a bid for a site expansion.

- The Screening and Monitoring Program (Neonatal Intensive Care Protocol) has been successfully piloted in both northern and southern regions.

- As a result of a number of Strategic Planning Workgroup meetings, six Effective Practice Guideline Modules were prepared for first draft reviews on July 29. These guidelines are: Foundation and Philosophy; Intake, Evaluation and Eligibility; Service Coordination; Individualized Family Service Plan; Transition; and Serving Children with Autism.

- A variety of trainings have increased the competencies of staff to provide appropriate intervention services with a concentration in the area of autism.

- Specialty teams i.e. autism, vision, hearing, etc. are being established and enhanced in order to increase the quality and quantity of services offered by early intervention staff.

- Families First offered four sessions to orient families on their rights and responsibilities. One of the sessions was provided in Spanish.

We Can't Do It Alone: Our Community Partners: Many people and agencies work with the Bureau of Early Intervention Services in supporting eligible families and strengthening the system.

SPECIAL THANKS TO THE EARLY INTERVENTION STAFF AND THE MANY FAMILIES WHO DEDICATE THEIR TIME AND TALENTS TO MEET THE DEVELOPMENTAL AND HEALTH-RELATED NEEDS OF NEVADA'S INFANTS AND TODDLERS.

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DEPARTMENT OF HUMAN RESOURCES
Nevada State Health Division
505 East King Street, Room 201
Carson City, Nevada 89701
http://health2k.state.nv.us

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